

		FOR OHF USE					

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**2000  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0040303</u>  <b>Facility Name:</b> <u>PRAIRIE VIEW CARE CENTER-LEWISTOWN</u>  <b>Address:</b> <u>175 E. SYCAMORE</u> <u>LEWISTOWN</u> <u>61542</u> <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Number</span> <span>City</span> <span>Zip Code</span> </div> <b>County:</b> <u>FULTON</u>  <b>Telephone Number:</b> <u>(847) 674-4700</u> <b>Fax #</b> <u>(847) 674-4733</u>  <b>IDPA ID Number:</b> _____  <b>Date of Initial License for Current Owners:</b> _____  <b>Type of Ownership:</b>  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b>  <input type="checkbox"/> Charitable Corp.  <input type="checkbox"/> Trust  <b>IRS Exemption Code</b> _____         </div> <div> <input checked="" type="checkbox"/> <b>PROPRIETARY</b>  <input type="checkbox"/> Individual  <input type="checkbox"/> Partnership  <input type="checkbox"/> Corporation  <input checked="" type="checkbox"/> "Sub-S" Corp.  <input type="checkbox"/> Limited Liability Co.  <input type="checkbox"/> Trust  <input type="checkbox"/> Other _____         </div> <div> <input type="checkbox"/> <b>GOVERNMENTAL</b>  <input type="checkbox"/> State  <input type="checkbox"/> County  <input type="checkbox"/> Other _____         </div> </div>	
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**In the event there are further questions about this report, please contact:**  
**Name** BOB KAGDA **Telephone Number:** ( 847 ) 675-3585

DPA 3745 (N-4-99)

IL478-2471

**Print Preview**



Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN# 0040303Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>50</u>	Skilled (SNF)	<u>50</u>	<u>18,300</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>49</u>	Intermediate (ICF)	<u>49</u>	<u>17,934</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>99</u>	TOTALS	<u>99</u>	<u>36,234</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			<u>1,610</u>	<u>1,610</u>	8
9	SNF/PED					9
10	ICF	<u>16,522</u>	<u>5,054</u>	<u>51</u>	<u>21,627</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,522</u>	<u>5,054</u>	<u>1,661</u>	<u>23,237</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4 64.13%)

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 02/01/93 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 10 and days of care provided 1610

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

\* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **PRAIRIE VIEW CARE CENTER-LEW** # **0040303** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**  
**V. COST CENTER EXPENSES** (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	99,982	6,006	7,945	113,933		113,933	0	113,933		1
2	Food Purchase		109,227		109,227		109,227	(4,464)	104,763		2
3	Housekeeping	81,817	19,280	0	101,097		101,097	247	101,344		3
4	Laundry	29,044	11,330	4,372	44,746		44,746	0	44,746		4
5	Heat and Other Utilities			54,838	54,838		54,838	195	55,033		5
6	Maintenance	21,254	14,789	8,096	44,139		44,139	65	44,204		6
7	Other (specify):*			3,921	3,921		3,921	0	3,921		7
8	<b>TOTAL General Services</b>	232,097	160,632	79,172	471,901		471,901	(3,957)	467,944		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,000	6,000		6,000	0	6,000		9
10	Nursing and Medical Records	654,448	38,989	54,928	748,365		748,365	3,968	752,333		10
10a	Therapy	19,828	487	2,665	22,980		22,980	0	22,980		10a
11	Activities	43,891	1,380	658	45,929		45,929	0	45,929		11
12	Social Services	36,628		492	37,120		37,120	0	37,120		12
13	Nurse Aide Training			0				0			13
14	Program Transportation			1,195	1,195		1,195	0	1,195		14
15	Other (specify):*							0			15
16	<b>TOTAL Health Care and Progra</b>	754,795	40,856	65,938	861,589		861,589	3,968	865,557		16
	<b>C. General Administration</b>										
17	Administrative	48,076		24,650	72,726		72,726	(3,054)	69,672		17
18	Directors Fees			0				0			18
19	Professional Services			27,407	27,407		27,407	11,505	38,912		19
20	Dues, Fees, Subscriptions & Promotions			24,210	24,210		24,210	(12,280)	11,930		20
21	Clerical & General Office Expense	26,868	14,941	73,174	114,983		114,983	(24,874)	90,109		21
22	Employee Benefits & Payroll Taxes			142,507	142,507		142,507	0	142,507		22
23	Inservice Training & Education			0				0			23
24	Travel and Seminar			2,393	2,393		2,393	3,879	6,272		24
25	Other Admin. Staff Transportation			8,433	8,433		8,433	1,437	9,870		25
26	Insurance-Prop.Liab.Malpractice			27,021	27,021		27,021	1,276	28,297		26
27	Other (specify):*			10,204	10,204		10,204	8,236	18,440		27
28	<b>TOTAL General Administration</b>	74,944	14,941	339,999	429,884		429,884	(13,875)	416,009		28
29	<b>TOTAL Operating Expense</b> (sum of lines 8, 16 & 28)	1,061,836	216,429	485,109	1,763,374		1,763,374	(13,864)	1,749,510		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEW # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			23,346	23,346		23,346	80,799	104,145		30
31	Amortization of Pre-Op. & Org.							1,127	1,127		31
32	Interest			95,659	95,659		95,659	274,856	370,515		32
33	Real Estate Taxes			22,197	22,197		22,197	0	22,197		33
34	Rent-Facility & Grounds			444,590	444,590		444,590	(326,469)	118,121		34
35	Rent-Equipment & Vehicles			1,015	1,015		1,015	2,148	3,163		35
36	Other (specify):*							0			36
37	TOTAL Ownership			586,807	586,807		586,807	32,461	619,268		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers		39,108	88,969	128,077		128,077	0	128,077		39
40	Barber and Beauty Shops							0			40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee			54,352	54,352		54,352	0	54,352		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers		39,108	143,321	182,429		182,429		182,429		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,061,836	255,537	1,215,237	2,532,610	0	2,532,610	18,597	2,551,207		45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

**FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.**

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **PRAIRIE VIEW CARE CENTER-LEWISTOWN**

# **0040303**

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

**VI. ADJUSTMENT DETAIL**

**A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**

**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	<b>NON-ALLOWABLE EXPENSES</b>				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals		2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		10		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation	(11,050)	30		9
10	Interest and Other Investment Income	0	32		10
11	Discounts, Allowances, Rebates & Refunds	(4,273)	2		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(191)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(300)	21		18
19	Entertainment	0	20		19
20	Contributions	0	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals		26		23
24	Bad Debt	(10,204)	27		24
25	Fund Raising, Advertising and Promotional	(13,433)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees		13		27
28	Yellow Page Advertising	(890)	20		28
29	Other-Attach Schedule DEFERRED MAINT XIX-H	0	6		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (40,341)		\$	30

OHF USE ONLY					
48		49	50	51	52

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)**

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	58,938	SCHED	34
35	Other- Attach Schedule	0	ATTACHED	35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ 58,938		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B)</b>	\$ 18,597		37

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport		X	\$	38
39					39
40	Gift and Coffee Shops		X		40
41	Barber and Beauty Shops		X		41
42	Laboratory and Radiology		X		42
43	Prescription Drugs		X		43
44	Exceptional Care Program		X		44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$	47

Print Preview







**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.**

**IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY	
													TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,464)	0	0	0	0	0	0	0	0	0	0	(4,464)	2
3	Housekeeping	0	0	247	0	0	0	0	0	0	0	0	247	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	195	0	0	0	0	0	0	0	0	195	5
6	Maintenance	0	0	65	0	0	0	0	0	0	0	0	65	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,464)</b>	<b>0</b>	<b>507</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(3,957)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	3,968	0	0	0	0	0	0	0	0	3,968	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Program</b>	<b>0</b>	<b>0</b>	<b>3,968</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,968</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	(24,650)	21,596	0	0	0	0	0	0	0	0	(3,054)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	11,505	0	0	0	0	0	0	0	0	11,505	19
20	Fees, Subscriptions & Promotions	(14,323)	0	2,043	0	0	0	0	0	0	0	0	(12,280)	20
21	Clerical & General Office Expenses	(300)	(59,073)	34,499	0	0	0	0	0	0	0	0	(24,874)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,879	0	0	0	0	0	0	0	0	3,879	24
25	Other Admin. Staff Transportation	0	0	1,437	0	0	0	0	0	0	0	0	1,437	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,276	0	0	0	0	0	0	0	0	1,276	26
27	Other (specify):*	(10,204)	0	18,440	0	0	0	0	0	0	0	0	8,236	27
28	<b>TOTAL General Administration</b>	<b>(24,827)</b>	<b>(83,723)</b>	<b>94,675</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,875)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(29,291)</b>	<b>(83,723)</b>	<b>99,150</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(13,864)</b>	<b>29</b>

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.  
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number: PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(11,050)	90,077	1,772	0	0	0	0	0	0	0	0	80,799	30
31	Amortization of Pre-Op. & Org.	0	1,127	0	0	0	0	0	0	0	0	0	1,127	31
32	Interest	0	274,562	294	0	0	0	0	0	0	0	0	274,856	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(329,453)	2,984	0	0	0	0	0	0	0	0	(326,469)	34
35	Rent-Equipment & Vehicles	0	0	2,148	0	0	0	0	0	0	0	0	2,148	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	<b>TOTAL Ownership</b>	<b>(11,050)</b>	<b>36,313</b>	<b>7,198</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>32,461</b>	<b>37</b>
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>44</b>
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	(40,341)	(47,410)	106,348	0	0	0	0	0	0	0	0	18,597	45

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

**VII. RELATED PARTIES**

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

[illegible]

```
Sum_6
-24650
-59200
-329453
90077
1127
274562
127
```

\* Total must agree with the total recorded on line 34 of Schedule D.

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

**Print Preview**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6d, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6d, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6f, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Print Preview

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	CERTIFIED HEALTH MANAGEMENT		\$ 247	\$ 247
16	V	5 ELECTRICITY & GAS		" " "		195	195
17	V	6 MAINTENANCE		" " "		65	65
18	V	10 NURSING & MEDICAL RECORDS		" " "		3,968	3,968
19	V	17 ADMIN SALARIES		" " "		21,596	21,596
20	V	19 PROFESSIONAL FEES		" " "		11,505	11,505
21	V	20 FEES, SUBSCRIPTION		" " "		2,043	2,043
22	V	21 OFFICE EXPENSE		" " "		34,499	34,499
23	V	27 EMPLOYEE BENEFITS		" " "		18,440	18,440
24	V	24 TRAVEL & SEMINAR		" " "		3,879	3,879
25	V	25 TRANSPORTATION		" " "		1,437	1,437
26	V	26 INSURANCE		" " "		1,276	1,276
27	V	30 DEPRECIATION		" " "		1,772	1,772
28	V	32 INTEREST		" " "		294	294
29	V	34 OFFICE RENT		" " "		2,984	2,984
30	V	35 EQUIPMENT RENT		" " "		2,148	2,148
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 106,348	\$ * 106,348

Sum\_6A

247  
195  
65  
3968  
21596  
11505  
2043  
34499  
18440  
3879  
1437  
1276  
1772  
294  
2984  
2148

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10a THERAPY	\$	CHM THERAPY		\$	\$	15
16	V	19 PROFESSIONAL FEE		" " "				16
17	V	21 OFFICE EXPENSE		" " "				17
18	V	27 EMPLOYEE BENEFITS		" " "				18
19	V	24 TRAVEL & SEMINARS		" " "				19
20	V	25 TRANSPORTATION		" " "				20
21	V	35 EQUIPMENT RENT		" " "				21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

Sum\_6B

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6C

\* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum\_6D

\* Total must agree with the amount recorded on line 34 of Schedule VI.

**DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.**

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE		SCHEDULE ATTACHED			SALARY	\$ 13,784	17-7	1
2	HOWARD GELLER		ADMINISTRATIVE					MGMT FEE	8,775	19-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 22,559		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview



| the name(s)  
PORTS.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 1/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CERTIFIED HEALTH MANAGEMENTStreet Address 3856 OAKTON SUITE 200City / State / Zip Code SKOKIE, IL 60076Phone Number ( 847 ) 674 - 4700Fax Number ( 847 ) 674 - 4733

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	282,193	8	\$ 3,000	\$ 23,237	\$ 247	1
2	5	ELECTRICITY & GAS	" " "	282,193	8	2,363	23,237	195	2
3	6	MAINTENANCE	" " "	282,193	8	794	23,237	65	3
4	10	NURSING & MEDICAL REC	" " "	282,193	8	48,193	23,237	3,968	4
5	17	ADMIN SALARIES	" " "	282,193	8	262,258	23,237	21,596	5
6	19	PROFESSIONAL FEES	" " "	282,193	8	103,352	23,237	11,505	6
7	20	FEES, SUBSCRIPTION	" " "	282,193	8	24,805	23,237	2,043	7
8	21	OFFICE EXPENSE	" " "	282,193	8	418,964	23,237	34,499	8
9	27	EMPLOYEE BENEFITS	" " "	282,193	8	223,938	23,237	18,440	9
10	24	TRAVEL & SEMINAR	" " "	282,193	8	47,103	23,237	3,879	10
11	25	TRANSPORTATION	" " "	282,193	8	17,449	23,237	1,437	11
12	26	INSURANCE	" " "	282,193	8	15,497	23,237	1,276	12
13	30	DEPRECIATION	" " "	282,193	8	21,518	23,237	1,772	13
14	32	INTEREST	" " "	282,193	8	3,570	23,237	294	14
15	34	OFFICE RENT	" " "	282,193	8	36,234	23,237	2,984	15
16	35	EQUIPMENT RENT	" " "	282,193	8	26,088	23,237	2,148	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,255,126	\$ 598,088		\$ 106,348	25

Print Preview



Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	SUCCESS BANK		X	MORTGAGE	\$7,359.00	4/00	\$ 365,314	\$ 326,173	9/01	10.5	\$ 30,411	1	
2	GERSHON BASSMAN	X		MORTGAGE	\$8,672.00	4/00	913,284	901,649	3/20	9.75	70,192	2	
3	CIB BANK		X	MORTGAGE	\$20,375.00	4/00	2,118,819	2,100,300	3/20	9.75	173,959	3	
4												4	
5	SHAREHOLDER/OFFICER	X		WORKING CAPITAL				1,186,709			75,352	5	
	Working Capital												
6	SUCCESS NATL BANK		X	LINE OF CREDIT				340,341		PRIME +	10,423	6	
7	SUCCESS NATL BANK		X	WORKING CAPITAL				0			9,884	7	
8	RELATED PARTY	X									294	8	
9	TOTAL Facility Related				\$36,406.00		\$ 3,397,417	\$ 4,855,172			\$ 370,515	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 3,397,417	\$ 4,855,172			\$ 370,515	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview



Facility Name & ID Number **PRAIRIE VIEW CARE CENTER-LEWISTOWN**# **0040303**Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>21,100</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>21,434</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>334</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>21,863</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>22,197</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>21,726</b>	8		
	1996	<b>21,939</b>	9		
	1997	<b>20,965</b>	10		
	1998	<b>20,723</b>	11		
	1999	<b>21,434</b>	12		

	<b>FOR OFF USE ONLY</b>		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATIO	\$	16

**THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL**

**THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR.**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

Print Preview

A. Square Feet: \_\_\_\_\_ B. General Construction Type: Exterior \_\_\_\_\_ Frame \_\_\_\_\_ Number of Stories \_\_\_\_\_  
 C. Does the Operating Entity? ☐ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☒ (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)  
 D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)  
 E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
 If so, please complete the following:  
 1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_  
 Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME			\$ 148,500	1
2					2
3	TOTALS			\$ 148,500	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		2000		\$ 2,673,000	\$ 68,856	27.5	\$ 68,856	\$	\$ 68,856	4
5											5
6											6
7											7
8						199		199			8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	AUTOMATIC SPRINKLER			1993	17,150	439	39	439		3,092	9
10	CONDENSOR			1993	2,414	62	39	62		462	10
11	EXPANDER			1993	6,354	163	39	163		1,175	11
12	NEW DOOR			1993	620	17	39	17		117	12
13	FIRE ALARM			1994	6,942	178	39	178		1,239	13
14	CUBICLE TRACKS & CURTAINS			1994	8,149	209	39	209		1,420	14
15	ARCHITECH CONSULTING			1994	1,050	27	39	27		174	15
16	TILE			1995	1,113	29	39	29		170	16
17	REPLACE SHINGLES			1997	1,075	27	39	27		101	17
18	MODIFIED BITUMEN RUBBER PLUMING & TILES			1997	13,173	338	39	338		1,254	18
19	INSTALL METALCAP			1997	2,670	68	39	68		247	19
20	ROOF REPAIR			1998	12,640	324	39	324		797	20
21	FLOOR TILE			1998	8,800	226	39	226		480	21
22	BATHROOM & CEILING REMODEL			1999	18,947	486	39	486		873	22
23	LANDSCAPING			1999	2,935	196	15	196		294	23
24	BOILER REPAIR			2000	2,159	308	20	54	(254)	54	24
25	NEW ROOF WEST WING			2000	6,000	27	27.5	27		27	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$ 72,179		\$ 71,925	\$ (254)	\$ 80,832	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

Report Period Beginning:

01/01/200( Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12B

Facility Name & ID Numbe PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12C

Facility Name & ID Numbe **PRAIRIE VIEW CARE CENTER-LEWISTOWN**

# **0040303**

Report Period Beginning: **01/01/2000** Ending: **12/31/2000**

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE  
REMOVE THE TEXT FROM COLUMN 2 OR 3.

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Page 12D

Facility Name & ID Numbe PRAIRIE VIEW CARE CENTER-LEWISTOWN

# 0040303

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
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32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				\$ #VALUE!	\$		\$	\$	\$	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number **PRAIRIE VIEW CARE CENTER-LEWISTOW# 0040303** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**

**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 99,833	\$ 11,432	\$ 9,983	\$ (1,449)	10 YRS	\$ 49,552	37
38	Current Year Purchases	11,167	1,700	558	(1,142)	10 YRS	558	38
39	Fully Depreciated Assets							39
40	RELATED PARTY	148,500	22,794	15,974	(6,820)	10 YRS	14,850	40
41	TOTALS	\$ 259,500	\$ 35,926	\$ 26,515	\$ (9,411)		\$ 64,960	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	MAINT,NURSING,ACT	1985 DODGE VAN	1996	\$ 4,775	\$ 550	\$ 596	\$ 46		\$ 4,775	42
43				20,436	6,540	5,109	(1,431)		7,664	43
44										44
45										45
46	TOTALS			\$ 25,211	\$ 7,090	\$ 5,705	\$ (1,385)		\$ 12,439	46

**E. Summary of Care-Related Assets**

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ #VALUE!	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 115,195	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 104,145	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (11,050)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 158,231	51

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

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## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO

If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized \_\_\_\_\_  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm: \$ 1,015 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_ \$ \_\_\_\_\_

13. \_\_\_\_\_ \$ \_\_\_\_\_

14. \_\_\_\_\_ \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p style="text-align: right;"> <input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO         </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p><b>THE FACILITY HIRES ONLY TRAINED AIDES.</b></p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**Print Preview**

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Facility Name & ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN# 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 32,654	\$		\$ 32,654	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,341			1,341	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			50,581			50,581	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				23,204		23,204	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12										
13	Other (specify):	39 - 2 & 3				4,393	15,904		20,297	13
14	TOTAL			\$		\$ 88,969	\$ 39,108		\$ 128,077	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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Facility Name &amp; ID Number PRAIRIE VIEW CARE CENTER-LEWISTOWN #

# 0040303

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 25,000 )	376,539		3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,585		6
7	Other Prepaid Expenses	1,053		7
8	Accounts Receivable (owners or related parties)	10,259		8
9	Other(specify): RE ESCROW	14,194		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 457,630	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	112,190		15
16	Equipment, at Historical Cost	136,211		16
17	Accumulated Depreciation (book methods)	(110,863)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 137,538	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 595,168	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 200,400	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,500		28
29	Short-Term Notes Payable	340,341		29
30	Accrued Salaries Payable	37,774		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,989		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,863		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	DEFERRED INCOME	35,340		36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 642,207	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,186,709		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	DUE TO LLC	1,024,515		43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 2,211,224	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,853,431	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ (2,258,263)	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 595,168	\$	48

\*(See instructions.)

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**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b>	
		<b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (1,724,901)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (1,724,901)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(533,362)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (533,362)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ (2,258,263)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

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Facility Name &amp; ID Number PRAIRIE VIEW CARE CENTER-LEWISTON # 0040303 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1		Amount	
Revenue			
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,181,331	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,181,331	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	70,102	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 70,102	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>DISCOUNTS</b>	4,273	28
28a	<b>PRIOR YEAR RENT ADJ</b>	(256,458)	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ (252,185)	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 1,999,248	30

2		Amount	
Expenses			
<b>A. Operating Expenses</b>			
31	General Services	\$ 471,901	31
32	Health Care	861,589	32
33	General Administration	429,884	33
<b>B. Capital Expense</b>			
34	Ownership	586,807	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	128,077	35
36	Provider Participation Fee	54,352	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,532,610	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(533,362)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (533,362)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Print Preview



**XVIII. A. STAFFING AND SALARY COSTS** (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,660	1,700	\$ 29,128	\$ 17.13	1
2	Assistant Director of Nursing	2,017	4,107	45,546	11.09	2
3	Registered Nurses	8,986	9,070	137,419	15.15	3
4	Licensed Practical Nurses	5,186	7,615	91,114	11.97	4
5	Nurse Aides & Orderlies	35,915	37,833	305,545	8.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,023	3,233	19,828	6.13	8
9	Activity Director	1,935	2,031	23,947	11.79	9
10	Activity Assistants	2,562	2,683	19,944	7.43	10
11	Social Service Workers	3,767	4,089	36,628	8.96	11
12	Dietician					12
13	Food Service Supervisor	1,960	2,080	18,854	9.06	13
14	Head Cook	8,322	8,804	53,030	6.02	14
15	Cook Helpers/Assistants	4,295	4,446	28,098	6.32	15
16	Dishwashers					16
17	Maintenance Workers	2,043	2,099	21,254	10.13	17
18	Housekeepers	10,807	11,309	81,817	7.23	18
19	Laundry	4,270	4,618	29,044	6.29	19
20	Administrator	2,389	2,509	48,076	19.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,132	2,220	26,868	12.10	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,850	1,936	21,241	10.97	31
32	Other Health Care(specify)					32
33	Other(specify) CARE PLAN	2,244	2,287	24,455	10.69	33
34	TOTAL (lines 1 - 33)	105,363	114,669	\$ 1,061,836 *	\$ 9.26	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	\$ 7,193	1-3	35
36	Medical Director	6,000	9-3	36
37	Medical Records Consultant	1,225	10-3	37
38	Nurse Consultant	0	10-3	38
39	Pharmacist Consultant	900	10-3	39
40	Physical Therapy Consultant	250	10a-3	40
41	Occupational Therapy Consultant	0	10a-3	41
42	Respiratory Therapy Consultant	0	10a-3	42
43	Speech Therapy Consultant	0	10a-3	43
44	Activity Consultant	658	11-3	44
45	Social Service Consultant	492	12-3	45
46	Other(specify)			46
47	PSYCHO-SOCIAL CONSULTANT	2,294	10-3	47
48				48
49	TOTAL (lines 35 - 48)	\$ 19,012		49

**C. CONTRACT NURSES**

	1	2	3	
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	\$	10-3	50
51	Licensed Practical Nurses		10-3	51
52	Nurse Aides		10-3	52
53	TOTAL (lines 50 - 52)	\$		53

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